


East West Medicine 

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship. *This notice takes effect on September 1, 2008 and will remain in effect until it is replaced or amended by changes in law.*

We gather personal information and health information in several ways:

- * Information we receive from you;
- * Information we receive from other healthcare providers; and
- * Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations.

You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosure will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls, or mail.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records. There is a copy fee of \$15 and up to 10 business days to process it.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information (PHI).
4. You have the right to request that we amend your Protected Health Information (PHI); the request must be in writing.
5. You have a right to receive all notices in writing.

If you have questions or complaints about our privacy practices, please contact our office for assistance. Send written complaints to the U.S. Department of Health and Human Services, 200 Independence Ave. SW, Washington, DC 20201.

Acknowledgement of Receipt of Notice of Privacy Practices & Authorization to Release Medical Information

I, _____, have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office. I agree that a copy of my medical record may be released to my physician, a designated referral physician who referred me here and other health care providers for the purpose of treatment.

Patient Signature _____ Date _____